

RESIDENTIAL

GROUP CARE QUARTERLY

VOLUME 4, NUMBER 4

CHILD WELFARE LEAGUE OF AMERICA

SPRING 2004

Reducing Reliance on Restrictive Techniques

By Shari Carlson

Chileda, a residential school in LaCrosse, Wisconsin, has committed the past 30 years to serving difficult-to-place children and young adults with developmental disabilities. The school serves 42 individuals from across the United States with diagnoses that include autism spectrum disorder, traumatic brain injury, Down's syndrome, oppositional-defiant disorder, intermittent explosive disorder, and low-incidence neurological disorders that involve acting out.

Chileda's educational program is individualized to meet each student's specific needs. As students grow older and individual needs change to include job exploration and work experiences, Chiledda's off-campus vocational center and community job experiences complement and eventually replace the classroom model.

Over the years, many students have arrived at Chiledda with behavioral approaches that relied on various restrictive techniques. In many cases, it seemed as if students had come to rely on other people and devices to control their behaviors. In some cases, these interventions had become a means for students to obtain sensory input and human contact.

Mechanical devices had become security blankets that had long ago become unnecessary for day-to-day personal protection and instead were relied upon to meet underlying, unmet needs. In other cases, students appeared to be traumatized by restraint, becoming more fearful, angry, and aggressive because of the approaches being used.

In early 2001, Chiledda set out on a systematic mission to reduce the use of all restrictive procedures. Since then, Chiledda has met the original goals, updated them, and accomplished a 100% reduction in the use of physical restraint and an 84.5% reduction in the use of seclusionary time-out. Moreover, these goals were accomplished with a statistically significant reduction in rates of staff injury. Most importantly, Chiledda has not increased reliance psychotropic medications.

The following strategies have helped make Chiledda successful in the ongoing goal of reducing use of restrictive techniques.

1. Measurable goals were set and shared with all staff. Weekly rates of restraint and seclusionary time-out use were graphed and posted to track progress.

See "Reducing Restrictive Techniques," page 3

INSIDE

Finding Better Ways 2004

Details on the upcoming conference in Atlanta, where participants will gather to share best practice models and strategies for responding to the changing face of residential services. —Page 2

Setting A New Standard

CWLA releases its new, revised *Standards of Excellence for Residential Services*. —Page 4

Program Evaluation in a Residential Youth Care Facility

Researchers take a closer look at Project PATCH in Oregon, where staff work to help youth improve the quality of their interactions with family members and peers. —Page 6

Point/Counterpoint

Is becoming restraint- and seclusion-free a realistic goal for residential providers? —Page 10

RESIDENTIAL GROUP CARE QUARTERLY

Volume 4, Number 4

LLOYD B. BULLARD
DIRECTOR OF
RESIDENTIAL CARE SERVICES

SCOTT KIRKWOOD
EDITOR

KATHERINE JOHNSON
RESEARCH ASSISTANT



SHAY BILCHIK
PRESIDENT/CEO

EVE MALAKOFF-KLEIN
PUBLICATIONS DIRECTOR

STEVEN S. BOEHM
ASSISTANT PUBLICATIONS DIRECTOR

Residential Group Care Quarterly (ISSN 1529-6954) is published four times a year by the Child Welfare League of America (CWLA). Printed in the USA. © 2004 Child Welfare League of America. No article may be reproduced by any means without permission from CWLA. Articles and advertising published in *Residential Group Care Quarterly* do not necessarily reflect the views of CWLA or its member agencies. Publication of an article or advertisement is not an endorsement of the author's opinions.

The Child Welfare League of America is the nation's oldest and largest membership-based child welfare organization. We are committed to engaging people everywhere in promoting the well-being of children, youth, and their families, and protecting every child from harm.

A list of staff in CWLA service areas is available on the Internet at www.cwla.org/whowhat/serviceareas.asp.

CHILD WELFARE LEAGUE OF AMERICA
HEADQUARTERS
440 FIRST STREET, THIRD FLOOR
WASHINGTON, DC 20001-2085
WWW.CWLA.ORG

Walker Trieschman to Host Finding Better Ways Conference in Atlanta May 3–5, 2004

By Nupur Gupta

The Child Welfare League of America's Walker Trieschman National Center for Professional Development, in collaboration with Residential Care Services and the Behavioral Health Division, presents the Finding Better Ways conference this year in Atlanta, May 3–5, 2004.

As funding for residential facilities diminishes, providers and researchers must respond by designing creative, innovative approaches to successfully serve this affected population of children, youth, and their families. To contribute to this effort, Finding Better Ways promises to share the best practice models and strategies for responding to the changing faces of residential services.

As such, Finding Better Ways is designed to target administrators, clinicians, supervisors, trainers, and direct-care staff from private and public agencies that provide a range of treatment and support services, and the consumers who receive them.

Agencies, child welfare and behavioral health professionals, researchers, and educators have the opportunity to showcase a variety of noteworthy programs, treatment models, and approaches. Participants will learn how to apply some of the accomplishments presenters have achieved in their communities, and learn lessons from their struggles and challenges.

This year's conference includes more than 60 workshops highlighting two critical areas: best-practice models and approaches, and managing and financing services. The first area addresses issues such as outcomes-

based approaches and treatment models, culturally competent service delivery, co-occurring mental health and substance abuse issues, approaches to working with gay, lesbian, bisexual, transgendered, and questioning youth, and best practices in behavior support and intervention.

The second area addresses such topics as leadership, workforce support and retention, information collection, management, protection, and quality improvement. By acknowledging both areas, the administration of residential services can be strengthened, and conference participants will be able to find solutions that address the challenges of the day.

In addition to workshops, the Finding Better Ways Exhibit Fair typically includes over 25 organizations with products of interest to conference participants, including treatment facilities, training and consultation, child education and activity programs, resource centers, employment services, insurance, furniture, and more.

By attending this stimulating conference, you'll not only gain an understanding of a number of promising practices and successful strategies for working with children, youth, and their families, but also find a renewed commitment to providing them the best possible residential services.

For more information, visit www.cwla.org/conferences/2004fbw.htm or contact Naomi Goldman at 617/769-4003 or nrau@cwla.org.

Nupur Gupta is a CWLA Program Assistant.

Reducing Restrictive Techniques

from page 1

2. Tracking efforts helped identify trends including where, when, and with whom restrictive techniques were more likely to occur. Modifications based on these trends include increased program structure during evenings and weekends.
3. Staff received extensive training on the risks of restraint-related positional asphyxia and the use of safe and therapeutic physical interventions to lower these risks.
4. Staff training focused on the use of proactive behavioral strategies, including:
 - identifying and including in written behavioral approaches the antecedents and early warning signs of behavioral escalation;
 - the use of creative de-escalation strategies such as changing staff, singing, paging someone to a different area, or using humor;
 - providing role-play opportunities for staff to practice and refine verbal intervention skills;
 - skill-building exercises to increase appropriate staff-to-student communication in areas including body language, tone of voice, and facial expressions; and
 - training to help staff control emotional responses during episodes of challenging behaviors.
5. Visual strategies were introduced to guide students including:
 - visual schedules and physical structure based on the TEACCH program (Treatment and Education of Autistic and related Communication-handicapped Children);
 - posted classroom rules;
 - student- and staff-initiated visual cues to indicate the need for help, a break, or to self-remove; and
 - increased use of various communication systems and devices for receptive and expressive communication.

6. Environmental accommodations were enacted to provide students with positive and enjoyable areas in which to calm down. Classrooms added defined relaxation areas containing items such as a vibrating recliner, beanbag chairs, video rockers, and a loft. Separate relaxation rooms were designed as a place where students could go on their own when they needed a break. These rooms were complete with carpeting, posters, beanbag chairs, pillows, and relaxing music.
7. Break opportunities using the relaxation rooms were provided on a proactive basis to give students positive associations with these environments.

No single factor led to the program's success—success was achieved through a combination of learning new skills and continuing to uncover new tools.

8. Students were reinforced for self-removal to a relaxation room even if they have displayed interfering behaviors before self-removal. As success is seen, the criteria for reinforcement is modified to include self-removal without interfering behaviors.
9. Individual behavioral programs and goals were initially designed to focus on replacing the most dangerous and concerning behaviors rather than attempting to replace all interfering behaviors. As a student succeeded in replacing these behaviors, additional modifications were made to the program to address other socially inappropriate behaviors. Behaviors that did not pose a risk to safety such as swearing and many

forms of property damage may have been tolerated as students learned means of self-control over more dangerous forms of acting out.

10. Individual programs were reviewed quarterly and adjusted as necessary to meet individual needs and find ways to eliminate the use of restrictive procedures.
11. Self-advocacy and social skill training were infused into all areas of programming. Students had opportunities to role-play social situations and refine appropriate social responses.
12. Chileda provided extensive training to help staff identify and address sensory sensitivities many students experienced.

An examination of Chileda's efforts to reduce reliance on restrictive techniques reveals that no single factor led to its success. Success was achieved through a combination of learning new skills and continuing to uncover new tools.

When we started to work toward reducing reliance on restrictive techniques, some people thought our goals were out of reach because of the nature of the students' challenging behaviors. In fact, before enrolling students at Chileda, some placing agencies and families expressed concerns about the ability to serve severely behaviorally challenged students without relying on restrictive interventions. Although alternative interventions are often more time-consuming and more creatively challenging, they are also more successful.

Chileda's students and staff have risen to this challenge and have proven that with the right combination of creativity and determination, anything is possible.

Shari Carlson is Director of Behavior Services at Chileda in LaCrosse, Wisconsin.

CWLA Publishes Revised Standards of Excellence for Residential Services

By Pam Day

CWLA is pleased to announce the publication of its revised *Standards of Excellence for Residential Services*. This newly revised volume of standards was developed under the guidance of a committee of individuals representing CWLA public and private member agencies throughout the country, researchers, and representatives of national organizations concerned with continually improving the quality of residential services.

The committee met for the first time in May 2002 to begin the process of reviewing CWLA's standards and suggesting additions and revisions. Its members began with the framework established in the 1991 volume and crafted standards that built on the philosophy, values, and practice recommendations of the earlier work. The committee circulated and reviewed drafts of chapters and received a draft of the completed revision in June 2003 for final review. CWLA's Board of Directors approved this volume in September 2004.

The new volume of standards builds on the previous volume in a number of ways. It emphasizes the importance of a range of supports and services for children and their families within a community context. It describes the unique features of the various types of residential care and suggests that residential providers have an important role in ensuring a continuum of services that meet the multiple needs of vulnerable children and families.

The standards address critical policy and practice issues such as building family and community involvement; creating a safe, nurturing service environment; promoting positive child, youth, and family development; and ensuring culturally competent practices. Each chapter

begins with a set of goals for achieving positive outcomes for children, youth, their families, and communities through residential services.

The introduction to the standards provides an overview of the historical and legislative context of residential services; describes the effect of changing social and economic conditions on families and children; introduces the *CWLA Framework for Community Action* as an overarching framework for supporting agencies and communities in improving child and family well-being; reviews recent developments in residential services; and elaborates on the roles, purposes, and desired outcomes of residential services.

Chapter 1 describes the array of residential service settings, specifically highlighting the primary purpose of any type of residential service, which is "to meet the needs of children who cannot live with their families or in a family setting and for whom more intensive service, such as hospitalization, is not needed."

Chapter 1 also briefly reviews the continuum or system of care that must be in place to ensure that children and families receive services that are coordinated, timely, and individualized to meet their needs.

Chapter 2 describes the process of service delivery, emphasizing the importance of reaching out to family members and achieving permanent family connections for children and youth. Families and professionals are integral to the assessment and service planning process. The role of the residential service provider in arranging aftercare services is also discussed.

Other critical pieces of services delivery include selecting the appropriate

residential service setting, intake and admission, assessment and service planning, monitoring and evaluating progress, discharge planning and the discharge process, and post-service and follow-up.

Chapter 3 reviews the universal service characteristics that should be common to all residential services, including cultural competence, flexibility, and a child-centered, family-focused philosophy that embraces the principles of positive youth development and empowers the child and family by building on their strengths.

The chapter also describes the elements of residential service and treatment that should be used to address the needs of children for safety, security, physical and behavioral health, stability, growth and development, education, and socialization. The chapter also includes the use of behavior support and intervention.

Chapter 4 details what needs to be in place organizationally and administratively to ensure that children, and families receive quality, culturally competent services and that all legal requirements are met. This chapter supplements the *CWLA Standards of Excellence for the Management and Governance of Child Welfare Organizations* [1996], the primary source on organization and management for all CWLA program standards volumes.

This chapter also emphasizes the importance of youth and family involvement in the design, delivery, oversight and evaluation of agency programs and services, and the important role the agency can play in involving the community to enrich overall services.

Chapter 5 addresses the environment of any residential setting, which

should convey to each child a sense of personal worth, dignity, and an entitlement to a safe, pleasant, comfortable atmosphere. The service environment should be located, designed, and equipped to meet the needs and characteristics of the children who live there. Important considerations in this chapter include location and relationships with the community and planning or building

the residential facility and characteristics of the facility, including physical space, furnishings, equipment, safety and maintenance.

Finally, Chapter 6 addresses the important role of the community in supporting and assisting children and families receiving residential services. It describes the roles, responsibilities, connections, and community resources that

are essential to meet the needs of children and their families. Finally, it encourages residential service providers to take a leadership role in building community advocacy for needed services and support.

Pam Day is CWLA's Director of Child Welfare Services and Standards.

COMMITTEE ON CWLA STANDARDS OF EXCELLENCE FOR RESIDENTIAL SERVICES

Carol Brown, Cochair
Mansfield, OH

Doug DeCerbo, Cochair
Boys Village Youth & Family Services
Milford, CT

Gretchen Antonelli
Stetson School, Inc.
Barre, MA

Chip Bonsutto
Catholic Charities Services
Corporation/ Parmadale
Parma, OH

Patsy Buida
US Health and Human Services/
Children's Bureau
Washington, DC

Sister Faith Colligan
Catholic Charities, USA
Alexandria, VA

Michael H. Danjczek
Children's Home of Easton
Easton, PA

Frank Delano
Jewish Board of Family and Children's
Services, Hawthorne, NY

Carmen Delgado Votaw
Alliance for Children and Families
Washington, DC

Susan Gardiner, Woods Homes
Calgary, Alberta, Canada

Kurt Garivaltis
Berkshire Farm Center for
Services and Youth
Canaan, NY

Sharon Gibbons
Washoe County Department
of Social Service
Reno, NV

The Hon. Ernestine Gray
Orleans Parish Juvenile Court
New Orleans, LA

Dr. Jennifer Jaworski
Children's Home and
Aid Society of Illinois
Evanston, IL

Beryl Kende
Jewish Board of Family
and Children's Services
Staten Island, NY

Mike Klein
Harmony Hill School
Chepachet, RI

Brad Klug
Rabiner Treatment Center
Fort Dodge, IA

David D. Lanier
Presbyterian Child Welfare Agency
Winchester, KY

Mary Mentaberry
National Council of Juvenile
and Family Court Judges
Reno, NV

James Murphy
KidsPeace/Seneca Woods Campus
Romulus, NY

Kathryn O'Day
Child and Family Tennessee
Knoxville, TN

Stephanie Pacinella
Council on Accreditation
New York, NY

Nick Paré
Batshaw Youth and Family Centres
Westmount, Quebec, Canada

Thomas Rembiesa
Ruth Dykeman Children's Center
Seattle, WA

Randy Rider
Crossroads/Fort Wayne Children's Home
Fort Wayne, IN

Lawrence D. Swartz
Executive Office of
Health and Human Services
Boston, MA

Donald Terrell
Attorney
Washington, DC

Program Evaluation in a Residential Youth Care Facility: The Case of Project PATCH

By Theodore W. McDonald

Well-designed program evaluations can be useful tools for organizations and agencies in both the business and social service sectors; they help organizations make important assessments about the strengths and weaknesses of their programs, areas in which their programs are meeting their goals, and areas in which their programs can be improved (Hoefler, 1994; Pfeiffer & Shott, 1996). Such evaluations have been conducted successfully in a number of residential treatment facilities (Bidgood & Pancer, 2001; Blackman, Eustace, & Chowdhury, 1991; Busch, 2003; Cote, Harris, & Vipond, 1986; Richardson, 1992) and have provided administrators and staff with valuable knowledge on how to improve their programs and services.

Several authors have commented on the methodologies necessary for quality program evaluations of residential treatment facilities. There seems to be some consensus that quality evaluations in the residential care arena feature assessment from intake to after discharge (Blackman et al., 1991; Busch, 2003; Cote et al., 1986; Mecca, Rivera, & Esposito, 2000; Whittaker, Overstreet, Grasso, & Tripodi, 1988) and involve collaboration among outside experts, facility administrators, staff, and youth enrolled in residential care, and their family members (Mecca et al., 2000; Pancer, 1985; Osher, van Kammen, & Zaro, 2001).

This article discusses an evaluation of the residential care program operated by Oregon-based Project PATCH (Planned Assistance for Troubled

Children). This evaluation used the critical methodologies described above, such as longitudinal assessment and collaborative efforts. This article aims to demonstrate how the success of the Project PATCH intervention was measured and to provide a framework for other residential treatment facilities to design and conduct program evaluations of their own.

Background and Methodology

Project PATCH, an organization dedicated to serving youth from troubled families, operates a residential care facility in Garden Valley, Idaho. For several years, the administrators, staff, and the board of directors had wanted to conduct an assessment of their services. In early 2003, the agency's treatment coordinator contacted the psychology department at Boise State University to ask if a faculty member or advanced student would be willing to help conduct such an evaluation.

Throughout the early spring, a team of faculty and students worked together with Project PATCH staff to develop a survey to assess the extent to which the program was meeting its unique goals, which included helping enrolled youth improve the quality of their interactions with family members and peers, reducing emotional distress, and increasing personal competencies. The investigators created a survey instrument with distinct subscales to measure each of these important target areas.

The first survey subscale, Family/Peer Interaction, asked parents to rate

their children for frequency of behaviors that indicate healthy social interaction (for example, willingly following family rules) and unhealthy social interaction (for example, hostility following a disagreement) both before and after the Project PATCH intervention.

The second subscale, Emotional Distress, asked parents to rate the frequency of feelings and behaviors that indicate emotional and behavioral problems (for example, feelings of depression, social isolation) before and after the Project PATCH intervention.

The final subscale, Personal Competency, asked parents to rate the frequency of behaviors that indicate adaptive social functioning (such as willingness to listen to others, showing responsibility, and setting goals) before and after the Project PATCH intervention.

Each question asked parents to rate behaviors on a 7-point Likert-type scale, with response values for behaviors ranging from "very rare" to "very frequent." By measuring the frequency of each behavior before and after Project PATCH participation, researchers were able to probe for statistically significant changes in behavior. The survey was mailed to parents of 138 youth who had previously been enrolled in Project PATCH. Forty-seven parents returned completed surveys.

Results

Average (mean) responses were calculated for each item concerning the frequency of child behaviors before and

after the Project PATCH intervention. Correlated groups' t-tests were used to measure for statistically significant differences in reported frequency of behavior before and after the intervention.

Family/Peer Interaction Subscale

Statistically significant differences in behavior frequency before and after Project PATCH were found for all eight items on the Family/Peer Interaction subscale (see Table 1). In other words, parent ratings of their children's behavior before and after Project PATCH differed markedly. As Table 1 shows, the parents in the sample found their children, after the Project PATCH intervention, to be

- more willing to be involved in family activities,
- more willing to follow family rules;
- less likely to be in conflict with family members,
- less likely to yell at or verbally abuse others,
- less likely to hit others or objects;
- less likely to show anger toward others,
- less likely to show hostility following a disagreement, and
- less likely to be involved in physical fights.

Although all of these changes were statistically significant, several were particularly dramatic. For example, post-

intervention or "after-PATCH" ratings of the frequency of conflict with family members fell 2.43 scale points from before the intervention, after-PATCH ratings of the frequency of showing anger toward others fell 2.28 scale points from before the intervention, and after-PATCH ratings of the frequency of willingly following family rules increased 2.04 scale points from before the intervention.

Emotional Distress Subscale

All four items on the Emotional Distress subscale yielded statistically significant differences in the frequency of feelings and behaviors, suggesting that involvement in Project PATCH led to measurable changes in participants' feelings and behavior. As Table 2 shows, the parents in the sample found their children, after the Project PATCH intervention, to exhibit

- fewer feelings of depression, hopelessness, and despair,
- fewer feelings or worry, anxiousness, or irritability,
- less isolation from social contacts, and
- fewer feelings of lethargy or lack of energy.

Clearly, these are all highly desirable results. The findings regarding the changes in perceived frequency of depression (a reduction of 1.95 scale

points) and anxiety (a reduction of 1.86 scale points) before and after the intervention were particularly encouraging.

Personal Competency Subscale

As Table 3 illustrates, all nine items on the Personal Competency subscale yielded statistically significant differences in the frequency of child behaviors before and after the Project PATCH intervention. The mean ratings given by parents in the sample suggest that after the Project PATCH intervention, children were

- more willing to express their feelings,
- more willing to discuss their problems,
- more willing to listen to others,
- more respectful of the views and opinions of others,
- more trustful of others,
- more respectful of others,
- more willing to work individually on projects such as chores and schoolwork,
- more likely to show responsibility, and
- more able to set and follow personal goals.

Although all of these results are highly desirable, some of the changes seemed particularly noteworthy. For example, parents' mean ratings revealed large changes in the frequency of respecting the views and opinions of others (an increase of 2.33 scale points), showing respect for others (an increase of 2.29 scale points), and showing responsibility (an increase of 2.05 scale points).

Satisfaction with Program Staff and Facilities

Although the goal of Project PATCH staff and administrators is to effect change in the behavior of program participants, they also want to make sure children's parents are satisfied with the quality of the staff and facilities at the youth ranches. To measure parent satisfaction with staff and facilities, two questions on the survey addressed these variables. Both asked parents to use

Table 1: Mean Behavior Frequency Ratings on Family/Peer Interaction Items Before and After Project PATCH

<u>Behavior Rated on Frequency</u>	<u>Before PATCH</u>	<u>After PATCH</u>
Being willingly involved in family activities	2.98* (1.70)	4.44* (2.02)
Willingly following family rules	2.39* (1.17)	4.43* (1.96)
Being in conflict with family members	5.87* (1.04)	3.44* (1.82)
Yelling at or verbally abusing others	4.58* (1.97)	2.80* (1.91)
Striking or hitting others or objects	2.93* (2.12)	1.68* (1.22)
Showing anger toward others	5.30* (1.75)	3.02* (1.84)
Showing hostility following a disagreement	5.21* (1.88)	3.30* (1.97)
Being involved in physical fights	2.50* (1.88)	1.61* (0.99)

Note. Standard deviations (in parentheses) indicate level of agreement in ratings across parents; higher standard deviations indicate less agreement in parent ratings. All ratings were made on 7-point scales where 1 = "very rare" and 7 = "very frequent"; thus, higher numbers reflect greater perceived behavior frequency. Asterisks indicate statistically significant changes in behavior frequency ($p < .05$) before and after the Project PATCH intervention.

Table 2: Mean Behavior Frequency Ratings on Emotional Distress Items Before and After Project PATCH

<u>Behavior Rated on Frequency</u>	<u>Before PATCH</u>	<u>After PATCH</u>
Feelings of depression, hopelessness, or despair	5.65* (1.48)	3.70* (1.83)
Feelings of worry, anxiousness, or irritability	5.56* (1.50)	3.70* (1.73)
Isolating himself or herself from social contacts	3.48* (2.13)	2.55* (1.85)
Feelings of lethargy or lack of energy	4.00* (2.28)	3.33* (2.11)

Note. Standard deviations (in parentheses) indicate level of agreement in ratings across parents; higher standard deviations indicate less agreement in parent ratings. All ratings were made on 7-point scales where 1 = “very rare” and 7 = “very frequent”; thus, higher numbers reflect greater perceived behavior frequency. Asterisks indicate statistically significant changes in behavior frequency ($p < .05$) before and after the Project PATCH intervention.

Table 3: Mean Behavior Frequency Ratings on Personal Competency Items Before and After Project PATCH

<u>Behavior Rated on Frequency</u>	<u>Before PATCH</u>	<u>After PATCH</u>
Willingness to express feelings	3.16* (1.89)	4.69* (1.86)
Willingness to discuss problems	2.49* (1.58)	4.39* (1.74)
Willingness to listen to others	2.76* (1.55)	4.60* (1.64)
Respecting the views and opinions of others	2.38* (1.13)	4.29* (1.51)
Trusting others	3.05* (1.54)	4.29* (1.51)
Showing respect for others	2.42* (1.10)	4.71* (1.54)
Working individually on projects (chores, schoolwork)	2.51* (1.66)	4.24* (1.93)
Showing responsibility	2.38* (1.19)	4.43* (1.95)
Setting and following personal goals	1.91* (.98)	3.86* (2.14)

Note. Standard deviations (in parentheses) indicate level of agreement in ratings across parents; higher standard deviations indicate less agreement in parent ratings. All ratings were made on 7-point scales where 1 = “very rare” and 7 = “very frequent”; thus, higher numbers reflect greater perceived behavior frequency. Asterisks indicate statistically significant changes in behavior frequency ($p < .05$) before and after the Project PATCH intervention.

7-point Likert-type scales to rate their satisfaction from “very dissatisfied” to “very satisfied.” As Table 4 shows, mean satisfaction ratings for both program leaders/staff and Project PATCH facilities were quite high (5.60 and 5.87, respectively, well above 4.00, the midpoint of the scale). These results suggest that the parents in the sample, as a whole, felt positively about the quality of the staff who interacted with their children, and the quality of the facilities at the ranch.

Perceptions of Overall Program Success

The success of Project PATCH was measured in two ways. The first involved measuring change in relevant participant feelings and behaviors before and after the intervention. The second was through two items at the end of the survey that simply asked parents to respond “yes” or “no” to questions about overall program success. The first question asked whether parents felt that, overall, the intervention had helped their children overcome problem behaviors; and the

second asked parents whether they would recommend Project PATCH to other families whose children were experiencing difficulties. The responses to these indicators were quite favorable (see Table 4). Of the parents who completed these items, 2 out of 3 felt the Project PATCH intervention had been successful overall, and nearly 9 out of 10 reported that they would recommend the program to other families (see Table 5).

Conclusions

The program evaluation was created to feature the methodologies considered crucial for residential treatment assessments (for example, longitudinal measurement and collaboration among interested parties), and used precise statistical tests designed to probe for significant program effects on key behavioral criteria. These procedures and methodologies increase the confidence in the validity of the evaluation’s results.

The success of this residential treatment program was immediately clear to the evaluators. Parents of the children enrolled in the program rated their children as better behaved, more emotionally healthy, and more personally and interpersonally competent on every outcome criterion.

These results obviously reflect extremely well on Project PATCH, as well as its facilities and staff. But they also provide important information for Project PATCH administrators about the areas in which the program is most successful, and areas in which the program is somewhat less successful. In short, a program evaluation like the one conducted for Project PATCH can make an already strong residential treatment program even more effective.

Administrators and staff at residential treatment centers everywhere can use many of the same procedures described in this article to conduct

program evaluations of their own. Several of these steps can be followed with some degree of ease, and doing so can ensure the program evaluation will not only be successfully conducted but will also yield important information.

The first important step involves contacting an outside evaluator with the expertise and ability to conduct an evaluation and the reputation to lend credibility to the results. Many residential treatment facilities are located near a college or university, and faculty and advanced students at these institutions are often willing to conduct such evaluations at no charge.

The second step requires discussions among the evaluators, program administrators and staff, and clients of the program to determine the program's key goals, and how they can best be measured.

The third step requires a survey instrument or other assessment tool that enables the evaluators to measure differences between feelings and behaviors at intake and after discharge.

The fourth step involves contemporary statistical methods and cogent report writing to provide the administrators and staff of a program with results they can use.

These procedures should ensure that a residential treatment facility or program can be effectively evaluated so relevant program staff can build on program strengths and address organizational shortcomings.

References

- Bidgood, B.A., & Pancer, S.M. (2001). An evaluation of residential treatment programs for young offenders in the Waterloo region. *Canadian Journal of Community Mental Health, 20*(2), 125–143.
- Blackman, M., Eustace, J., & Chowdhury, T. (1991). Adolescent residential treatment: A one to three year follow-up. *Canadian Journal of Psychiatry, 36*(7), 472–479.

Table 4: Parent Satisfaction with Project PATCH Staff and Facilities

Item	Satisfaction Rating (M)
How satisfied were you with the Project PATCH program leaders/staff?	5.60 (1.67)
How satisfied were you overall with the Project PATCH facilities?	5.87 (1.58)

Note. Standard deviations (in parentheses) indicate level of agreement in ratings across parents; higher standard deviations indicate less agreement in parent ratings. Both satisfaction ratings were made on 7-point scales where 1 = “very dissatisfied” and 7 = “very satisfied”; thus, higher numbers reflect greater satisfaction.

Table 5: Perceptions of Overall Program Success of the Project PATCH Intervention

Item	Yes	No
Overall, do you feel that Project PATCH has been successful in helping your child overcome problem behaviors?	66.7%	33.3%
Would you recommend Project PATCH to other families with children who are experiencing difficulties?	88.4%	11.6%

Note. Five parents (10.6% of the sample) did not respond to the item asking about overall program success; four parents (8.5% of the sample) did not respond to the item asking about program recommendations.

- Busch, M. (2003). Outcome measures in residential group care: A state association model project: Part I. *Residential Group Care Quarterly, 4*(1), 1–3.
- Cote, J.E., Harris, D.P., & Vipond, E. (1986). A psychometric evaluation of a residential treatment facility: An illustration of an interpretable design without a control group. *Adolescence, 21*(81), 67–79.
- Hoefler, R. (1994). A good story, well told: Rules for evaluating human services programs. *Social Work, 39*(2), 233–236.
- Mecca, W.F., Rivera, A., & Esposito, A.J. (2000). Instituting an outcomes assessment effort: Lessons from the field. *Families in Society, 81*(1), 85–91.
- Osher, T.W., van Kammen, W., & Zaro, S.M. (2001). Family participation in evaluating systems of care: Family, research, and service system perspectives. *Journal of Emotional & Behavioral Disorders, 9*(1), 63–70.
- Pancer, S. M. (1985). Program vs. evaluation: Reconciling the needs of service providers and program managers. *Canadian Journal of Community Mental Health, 4*(2), 83–92.
- Pfeiffer, S.I., & Shott, S. (1996). Implementing an outcome assessment project: Logistical, practical, and ethical considerations. In S.I. Pfeiffer (Ed.), *Outcome assessment in residential treatment*. New York: Haworth Press.
- Richardson, W. (1992). The use of program-evaluation data in the decision-making process of a children's mental health centre: A case study. *Journal of Child and Youth Care, 7*(1), 61–70.
- Whittaker, J.K., Overstreet, E.J., Grasso, A., & Tripodi, T. (1988). Multiple indicators of success in residential youth care and treatment. *American Journal of Orthopsychiatry, 58*(1), 143–147.

Theodore McDonald is Assistant Professor, Department of Psychology, Boise State University.

Q: *Is becoming restraint- and seclusion-free a realistic goal for residential providers?*

POINT: Providers can work toward the goal of zero restraint and seclusion, and agencies that control their own admissions and discharges may be able to achieve and sustain this goal by being selective in their admission process and discharging those children who require restraint and seclusion.

By Jermaine H. Johnson

I have always dreamed of operating a restraint-free facility. As it stands, my agency has a very low rate of restraints: One per year would be an overstatement. In looking more closely at that goal, I see two core issues that systemically lead to cracks in agencies looking to create a restraint-free foundation.

The first is an agency's internal structure. The reality is that to have a restraint-free facility, organizations must adopt an agencywide philosophy. And it's more than just a policy. A policy will not be supported or followed if the staff implementing that policy don't believe in it. An agency must adopt the belief that it has many other options to pursue before resorting to restraint.

We must recognize that children who have suffered severe emotional and physical abuse could perceive a hands-on approach as perpetuating past abuse. It's essential to educate staff on the injuries, trauma, and deaths that can occur during a restraint.

We must train staff to respond to crisis situations in ways that deescalate rather than escalate. An agency must be willing to provide ongoing trainings around the type of clients it serves and the most effective interventions when working with them.

An agency must create an environment that is very supportive and appreciative of its staff. Staff must believe they are supported in their jobs and understand they have a voice in the process.

see "Point," page 12

COUNTERPOINT:

Providers nationwide have eliminated entirely the use of restraint and seclusion. Becoming restraint free is a process that can be sustained through continual efforts that focus on the reduction and elimination of restraint and seclusion.

By Jim Sinclair

Eliminating restraint and seclusion is a hot-button topic among residential group care providers and others delivering human services. Some in our profession view restraint and seclusion as a therapeutic intervention whereas others consider it a treatment failure. But it is neither. Rather, it's a question of what is the best course of action based on the circumstances facing the client and the staff. Is a restraint the best response? Is seclusion the best response? Or, is there another alternative that will help the client in need? For most interactions, a choice other than restraint or seclusion is usually available.

The question then becomes, "Can a provider obtain a restraint- and seclusion-free environment?" The answer is obviously, "Yes," as some providers already have. At a minimum, a provider can obtain substantial compliance with such a goal (meaning no restraints except those for safety that involve life-or-death situation.)

So how does one do that? The answer is a process rather than a single event, and it must be sustained by continual efforts from all levels of the organization. This effort will succeed only if both the organization's leadership and staff are committed to eliminating restraint and seclusion.

After nearly five years, my organization, Gibault, is still in the midst of the process, as we serve about 100 clients, all with a *DSM-IV* diagnosis, and one-third with a sexual disorder/reactive diagnosis. The use of mechanical restraints and seclusion were eliminated in a two-year period, but the elimination, or perhaps more appropriately, "substantial

see "Counterpoint," page 11

compliance” with the elimination of physical restraint will take much longer.

How was seclusion eliminated at Gibault? The process began in 1999 with talking with staff and floating the philosophy of reduction. A complete review of state licensing regulations and Council on Accreditation standards with select staff took a couple of weeks.

As the leader of Gibault, I knew that, although I could articulate particular philosophy of treatment, successfully implementing that philosophy depended on program directors and, in particular, program staff.

I still have yet to direct the elimination of seclusion. Back in 1999, I merely told Gibault’s program directors and staff I would like to see Gibault reduce its usage. We also instituted a procedure requiring the approval of two program heads to implement seclusion—the director of residential operations and the director of clinical operations.

The seclusion rooms were also put under the authority of the director of clinical operations rather than the director of residential operations, as we’d done previously. Gibault also had a mobile crisis team in the safety and security unit. This crisis team was available 24 hours a day to respond to any campus crisis, behavioral or otherwise.

We provided two-way radios to staff, drastically improving their ability to get backup assistance when needed. The group living unit supervisor was assigned as case manager of the clients, replacing therapists. This heightened residential responsibility for the client, once the sole domain of the clinicians, and resulted in more ownership of the cases by the supervisor. Vesting the case responsibility in residential services’ staff, who care for the client most of the time, also gave staff more ownership of the process.

Under the day-to-day leadership of the two directors and the buy-in of staff, seclusion was gradually reduced

and eliminated. Gibault had three locked seclusion rooms in 1999; today it has one and staff have not used locked seclusion in approximately two years. Although some worried that eliminating locked seclusion would lead to a rise in restraints, a slight increase in that area eventually leveled off. Gibault also saw a reduction in the prevalence of AWOLs once seclusion was eliminated.

Was eliminating seclusion and mechanical restraints easy? Not at all. Some staff challenged me to... show them what I wanted done. Others said I was out of touch.

After the process of eliminating seclusion was completed, mechanical restraints were next. Mechanical restraints were originally available to all residential staff, but during the reduction process, their use was restricted to the safety and security staff. Gradually, the safety and security staff decreased their use of restraint, and the techniques were made available only to the supervisors of safety and security. Finally, after six months, all mechanical restraints were collected, and they are no longer in use at Gibault.

Was eliminating seclusion and mechanical restraints easy? Not at all. Some staff challenged me to come to a dorm and show them what I wanted done. Others said I was out of touch and didn’t know how rough it was in the dorms. During the transition, some clients even asked me to return Gibault to the way it was before. Some staff became angry and fearful, displaying a lack of confidence in their own abilities. In their opinion, treatment tools had been taken away from them with-

out new ones being provided. From our standpoint, our staff had the training and ability but had never been asked to use it.

During any change process and, in fact, as a matter of routine management, staff roundtables are a must. The same can be said about client roundtables. Staff and clients must have separate vehicles for voicing their concerns, wants, and needs. It was just as crucial for the organization’s leaders to stay on message and help staff recognize that seclusion and mechanical restraints were not treatment tools but rather the temporary management of behavior. It’s also prudent to help staff stay focused on deescalation techniques—therapeutic crisis intervention or its equivalent—by active supervision and constant retraining.

Proper staffing ratios and smaller living groups are a must for eliminating seclusion and restraint. (In 1999, staffing ratios were routinely 1 to 18; ratios now are at most 1 to 6, and living groups are no larger than 12. Four units, will be opening soon with client capacity set at 5.)

Reducing restraint, and eventually substantial compliance with eliminating restraints, is next for Gibault. We are in the embryonic stage of that process. Is it possible? Yes. Will it be attained completely? No. Even SAMSHA Administrator Charles Currie has said there is a need for physical restraint to preserve the safety of the client.

Does the possibility that restraints cannot be fully eliminated mean a residential treatment provider shouldn’t strive for a restraint-free environment? No. We must strive for that visionary environment. It’s in the best interest of our clients.

Jim Simpson is Executive Director of Gibault, in Terre Haute, Indiana. For more information, see www.gibault.org.

That last notion might appear unrelated, but if staff are valued and respected, they are more likely to take ownership in the program and its processes. This type of approach helps reduce restraints and increase staff competency, staff confidence, and crisis intervention methods.

Budget cuts are being made all over the country and as a result, private agencies are receiving much tougher referrals than in the past.

The second core issue is external to the agency. It's difficult to eliminate restraints if kids in need of a higher level of care are referred to programs with a lower level of care. Budget cuts are being made all over the country and quality programs are suffering by reduction in size and services or elimination. As a result, private agencies are receiving much tougher referrals than in the past.

Because of budget limitations, kids are being moved to the least restrictive environment with just enough treatment. Small and private agencies no longer have the luxury of selective admissions, as many are already facing extinction.

Moreover, smaller agencies cannot afford payroll expenses comparable to psychiatric hospitals, so they are often understaffed. A smaller staff facing tougher kids does not allow an agency to adequately or effectively use other resources and internal support systems to fully eliminate restraints.

I wonder if it really is possible to be restraint-free. If an agency only has one restraint in three years, can that agency be considered restraint-free or restraint-light? At this time in the human services arena, it may be more realistic for an agency to approach the issue with the goal of being restraint-

free, while acknowledging that a restraint may need to happen to ensure the safety and well-being of clients and staff.

Jermaine Johnson is Assistant Executive Director, Adolescent & Family Growth Center, Springfield, VA.

FEEDBACK

Would you like to sound off on an emerging issue in residential care?

RESIDENTIAL GROUP CARE QUARTERLY

*is the perfect forum for your ideas.
Share your knowledge and thoughts
with your peers today!*

SUBMISSIONS OF ALL KINDS ARE WELCOME:

LETTERS TO THE EDITOR
NEW TOOLS
COMMENTARIES
TREND ANALYSIS
CASE STUDIES
REVIEWS

SEND SUBMISSIONS TO

**Residential Group Care Quarterly
Child Welfare League of America**

440 First Street NW, Third Floor
Washington DC 20001-2085

Phone: 202/942-0280, Fax: 202/737-3687

E-mail: rgcq@cwla.org

All submissions may be edited for space and clarity.

In the next Residential Group Care Quarterly Point/Counterpoint...

Question: Is residential care a cost-effective service?

Point: Most residential care providers are badly under-funded. It's almost impossible to find any residential provider that's reimbursed at its level of cost. In fact, good residential care is a cost-effective service that is needed and effective in spite of being extremely underfunded.

Counterpoint: In general, residential care is a costly service that is overused and does not produce positive outcomes. Although residential care is useful under limited circumstances, these funds would more often be better used supporting birth and foster families.